

HEALTHY KIDS DEpartment of Social EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) & Health Services REFERRAL FOR MENTAL HEALTH/SUBSTANCE ABUSE ASSESSMENT

| SECTION I. PATIENT INFORMATION | | | | | |
|--|-------------------------------|--------------------------|-----------------------------|---------------------|------------------------|
| 1. PATIENT'S NAME | 2. | . sex ☑ Male ☑ Female | 3. PATIENT IDENTIFICATION (| CODE (PIC) | 4. BIRTH DATE |
| 5. RACE 6. PARENT'S | S/GUARDIAN'S NAME | | 7. RELATIONSHIP TO PATIEN | T 8 TELEP | HONE NUMBER |
| 6. 17.11E.111 C | WOOTH CONTINUE | | 7. REBUIONOUM TOTAMEN | 0. 12221 | HONE NOMBER |
| 9. STREET ADDRESS | | CITY | | STATE | ZIP CODE |
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| SECTION II. PRIMARY CARE PRO | VIDER INFORMATION | | | | |
| PRIMARY CARE PROVIDER'S NAME | | 2. TELEP | HONE NUMBER | 3. | DATE OF SCREENING |
| 4. STREET ADDRESS | | CITY | | STATE | ZIP CODE |
| 4. STREET ADDRESS | | CITT | | SIAIL | ZIF GODE |
| 5. LIST THE MEDICATION(S) THE PATIENT IS 0 | CURRENTLY TAKING | 6. LIST P | HYSICAL CAUSES THAT WERE R | RULED OUT | |
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| 7. DESCRIBE PREVIOUS MENTAL HEALTH/SU | DOTANICE ADUSE SEDVICES DECEI | VED | | | |
| 7. DESCRIBE PREVIOUS MENTAL HEALTH/SU | BSTANCE ABUSE SERVICES RECEI | VED | | | |
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| 8. REFERRAL TYPE | 9. REFERRED TO: | | | | |
| Regular Urgent | Mental Health As | ssessor \square S | ubstance Abuse Assessor | · | gional Support Network |
| 10. REASON FOR REFERRAL | | | | | |
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| 11. PHYSICIAN'S/PHYSICAL EXAMINER'S SIGN | IATURE | | | | DATE |
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| SECTION III. PATIENT INTERPRET | TATION CERTIFICATION | | | | |
| I certify that the above referral | was evolained to | | | | |
| r certify that the above referral | was explained to | | PATIENT OR PARENT/GUA | RDIAN | |
| in | and | executed in my prese | ence. | | |
| LANGUAGE | | , ۲ | | | |
| WITNESS/INTERPRETER'S SIGNATURE | | | | | DATE |
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| SECTION IV. COMPLETED BY THE 1. ASSESSMENT RECEIVED | E ASSESSOR AND RETURN | IED TO THE HEALTHY | KIDS PRIMARY CARE F | PROVIDER LISTE | D ABOVE |
| | ne; explain: | | | | |
| ☐ Substance abuse | ., . , | | | | |
| 2. INITIAL TREATMENT PLAN | | | | | |
| | | | | | |
| | | | | | |
| 3. EXPLAIN WHY IF NO SERVICES ARE NEEDE | ED | | | | |
| | | | | | |
| 4. ASSESSOR'S NAME | | DATE | E - | TELEPHONE NUMBER | |
| A. ASSESSOR S NAIVIE | | DATE | 5. | LELL HOINE NUIVIDER | |
| DSHS 01-192 (REV. 07/1994) | | | | Ca | for instructions |

See reverse for instructions.



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| SECTION I. PATIENT INFO | ORMATION | | | | 1 | | |
|--|-----------------|---|-----------|---------------|---------------------------|------------------|--------------------------|
| 1. PATIENT'S NAME | | | 2. SEX | Female | 3. PATIENT IDENTIFICATION | ON CODE (PIC) | 4. BIRTH DATE |
| 5. RACE | 6. PARENT'S/GUA | RDIAN'S NAME | | | 7. RELATIONSHIP TO PAT | TIENT 8. TE | ELEPHONE NUMBER |
| 9. STREET ADDRESS | | | | CITY | | STATE | ZIP CODE |
| SECTION II. PRIMARY CA | | ER INFORMATION | | 1 | | | |
| PRIMARY CARE PROVIDER'S N. | AME | | | 2. TELEPF | IONE NUMBER | | 3. DATE OF SCREENING |
| 4. STREET ADDRESS | | | | CITY | | STATE | ZIP CODE |
| 5. LIST THE MEDICATION(S) THE R | PATIENT IS CURR | ENTLY TAKING | | 6. LIST PH | YSICAL CAUSES THAT WE | RE RULED OUT | |
| 7. DESCRIBE PREVIOUS MENTAL | | | CEIVED | | | | |
| 8. REFERRAL TYPE Regular U | | REFERRED TO: Mental Health | Assessor | ☐ Su | ıbstance Abuse Asses | ssor | Regional Support Network |
| | | | | | | | |
| 11. PHYSICIAN'S/PHYSICAL EXAM | INER'S SIGNATUR | RE | | | | | DATE |
| SECTION III. PATIENT IN | TERPRETATI | ON CERTIFICATION | | | | | |
| I certify that the above | referral was | explained to | | | | | |
| | | _ | | | PATIENT OR PARENT/ | GUARDIAN | |
| in | ANGUAGE | an | d execute | d in my prese | nce. | | |
| WITNESS/INTERPRETER'S SIGNAT | TURE | | | | | | DATE |
| SECTION IV. COMPLETE 1. ASSESSMENT RECEIVED Mental health Substance abuse | D BY THE AS | | RNED TO T | THE HEALTHY | KIDS PRIMARY CAR | E PROVIDER LIS | STED ABOVE |
| Substance abuse Initial Treatment Plan | | | | | | | |
| 3. EXPLAIN WHY IF NO SERVICES | ARE NEEDED | | | | | | |
| 4. ASSESSOR'S NAME | | | | DATE | | 5. TELEPHONE NUM | IBER |
| DSHS 01-192 (REV. 07/1994) | | | | | | See reve | arse for instructions |

See reverse for instructions.



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| SECTION I. PATIENT INFORMATION | | | | | |
|---|------------------------------------|-----------------------|----------------------------|------------------|------------------------|
| 1. PATIENT'S NAME | 2. | sex]Male □ Female | 3. PATIENT IDENTIFICATION | CODE (PIC) | 4. BIRTH DATE |
| 5. RACE 6. PARENT'S/0 | GUARDIAN'S NAME | iviale remale | 7. RELATIONSHIP TO PATIEN | IT 8 TELEP | HONE NUMBER |
| o. PARENTON | SOARDIAN O NAME | | 7. RELATIONORIII TOTATIEN | O. TEELT | HONE NOWIDER |
| 9. STREET ADDRESS | | CITY | | STATE | ZIP CODE |
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| SECTION II. PRIMARY CARE PROV | IDER INFORMATION | | | | |
| PRIMARY CARE PROVIDER'S NAME | | 2. TELEP | HONE NUMBER | 3. | DATE OF SCREENING |
| 4. STREET ADDRESS | | CITY | | STATE | ZIP CODE |
| 4. OTTELT ABBILLOG | | OHT | | OIME | 211 0002 |
| 5. LIST THE MEDICATION(S) THE PATIENT IS CU | JRRENTLY TAKING | 6. LIST PI | HYSICAL CAUSES THAT WERE F | RULED OUT | |
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| 7. DESCRIBE PREVIOUS MENTAL HEALTH/SUB | STANCE ABUSE SERVICES RECEIV | ED | | | |
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| 8. REFERRAL TYPE | 0. 05550050.70 | | | | |
| Regular Urgent | 9. REFERRED TO: Mental Health Ass | essor S | ubstance Abuse Assesso | r Red | gional Support Network |
| 10. REASON FOR REFERRAL | World Floatif 7.00 | | | | Jonai Support Notwork |
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| 11. PHYSICIAN'S/PHYSICAL EXAMINER'S SIGNA | TURE | | | | DATE |
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| SECTION III. PATIENT INTERPRETA | ATION CERTIFICATION | | | | |
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| I certify that the above referral w | as explained to | | PATIENT OR PARENT/GUA | ADDIAN | |
| in | | | | ARDIAN | |
| in | and e | xecuted in my prese | ence. | | |
| WITNESS/INTERPRETER'S SIGNATURE | | | | | DATE |
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| SECTION IV. COMPLETED BY THE | ASSESSOR AND RETURNE | D TO THE HEALTHY | KIDS PRIMARY CARE I | PROVIDER LISTE | D ABOVE |
| 1. ASSESSMENT RECEIVED | | | | | |
| ☐ Mental health☐ Nor☐ Substance abuse | ne; explain: | | | | |
| Substance abuse Initial Treatment Plan | | | | | |
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| 3. EXPLAIN WHY IF NO SERVICES ARE NEEDED |) | | | | |
| | | | | | |
| | | | | | |
| 4. ASSESSOR'S NAME | | DATE | 5. | TELEPHONE NUMBER | |
| DSHS 01-192 (REV. 07/1994) | | | | | |
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See reverse for instructions.



HEALTHY KIDS DEpartment of Social EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) & Health Services REFERRAL FOR MENTAL HEALTH/SUBSTANCE ABUSE ASSESSMENT

| SECTION I. PATIENT IN | FORMATION | | | | | |
|-------------------------------|--|-----------------|------------|---------------------------|---------------|----------------------------|
| 1. PATIENT'S NAME | | 2. SEX | | 3. PATIENT IDENTIFICATION | ON CODE (PIC) | 4. BIRTH DATE |
| | | ☐ Male ☐ F | emale | | | |
| 5. RACE | 6. PARENT'S/GUARDIAN'S NAME | | | 7. RELATIONSHIP TO PAT | IENT | 8. TELEPHONE NUMBER |
| 9. STREET ADDRESS | | | CITY | | 91/ | ATE ZIP CODE |
| 9. STREET ADDRESS | | ` | 511 1 | | 317 | ATE ZIF CODE |
| SECTION II DRIMARY | CARE PROVIDED INCORMATION | | | | | |
| PRIMARY CARE PROVIDER'S | NAME | 2 | 2. TELEPH | ONE NUMBER | | 3. DATE OF SCREENING |
| | | | | | | |
| 4. STREET ADDRESS | | (| CITY | | STA | ATE ZIP CODE |
| | | | | | | |
| 5. LIST THE MEDICATION(S) THI | E PATIENT IS CURRENTLY TAKING | 6 | 6. LIST PH | YSICAL CAUSES THAT WEF | RE RULED OUT | |
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| 7 DESCRIBE PREVIOUS MENTA | AL HEALTH/SUBSTANCE ABUSE SERVICES REC | CEIVED | | | | |
| The Bedering Prince of Mexico | | 22.122 | | | | |
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| 8. REFERRAL TYPE | 9. REFERRED TO: | | | | | |
| - | Urgent ☐ Mental Health | Assessor | ∐ Su | bstance Abuse Asses | sor | ☐ Regional Support Network |
| 10. REASON FOR REFERRAL | | | | | | |
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| 11. PHYSICIAN'S/PHYSICAL EXA | MINER'S SIGNATURE | | | | | DATE |
| | | | | | | |
| SECTION III. PATIENT I | NTERPRETATION CERTIFICATION | | | | | |
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| I certify that the above | ve referral was explained to | | | | | |
| | | | | PATIENT OR PARENT/0 | GUARDIAN | |
| in | an | d executed in m | y prese | nce. | | |
| WITNESS/INTERPRETER'S SIGN | ATURE | | | | | DATE |
| WITH EOGH TERN O GIOT | ATORE . | | | | | |
| SECTION IV COMPLET | ED BY THE ASSESSOR AND RETU | RNED TO THE HE | ΑΙ ΤΗΥ | KIDS PRIMARY CAR | E PROVIDE | R LISTED ABOVE |
| ASSESSMENT RECEIVED | ED BY THE ASSESSOR AND RETOR | KINED TO THE HE | | RIDO I KIMAKI CAK | LIKOVIDLI | CLISTED ABOVE |
| | ☐ None; explain: | | | | | |
| ☐ Substance abuse | | | | | | |
| 2. INITIAL TREATMENT PLAN | | | | | | |
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| 3. EXPLAIN WHY IF NO SERVICE | ES ARE NEEDED | | | | | |
| | | | | | | |
| 4. ASSESSOR'S NAME | | - | DATE | | 5. TELEPHONE | E NII IMDED |
| 4. ASSESSOR S NAME | | l. | JAIE | | J. IELEPHUNE | . INUIVIDER |
| DSUS 01-102 (DEV. 07/1004) | | | | | | |

INSTRUCTIONS

SECTION I. PATIENT INFORMATION

- 1. PATIENT'S NAME: The name of the patient being screened.
- 2. SEX: The sex of the patient being screened.
- 3. PATIENT IDENTIFICATION CODE (PIC): The state-assigned PIC number printed on the medical coupon.
- 4. BIRTH DATE: The birth date (month/day/year) of the patient being screened.
- 5. RACE: The patient's race.
- 6. PARENT'S/GUARDIAN'S NAME: The name of the patient's parent or legal guardian, if the patient is under 18 years of age.
- 7. RELATIONSHIP TO PATIENT: Mother, father, grandmother, legal guardian, etc.
- 8. TELEPHONE NUMBER: The telephone number of the patient, or parent/guardian if the patient is not the responsible party for authorizing the mental health and/or drug/alcohol referral and exchange of medical information.
- 9. STREET ADDRESS, CITY, STATE, AND ZIP CODE: The full address of the patient, or parent/guardian if the patient is not the responsible party for authorizing the mental health and/or drug/alcohol referral and exchange of medical information.

SECTION II. PRIMARY CARE PROVIDER INFORMATION

- 1. PRIMARY CARE PROVIDER'S NAME: The name of the primary care provider.
- 2. TELEPHONE NUMBER: The telephone number of the primary care provider.
- 3. DATE OF SCREENING: The date (month/day/year) the Healthy Kids/EPSDT screen was done.
- 4. STREET ADDRESS, CITY, STATE, AND ZIP CODE: The full address of the primary care provider.
- 5. LIST THE MEDICATION(S) THE PATIENT IS CURRENTLY TAKING: List the medication you are aware that the patient is taking, including prescription, over-the-counter, and illegal drugs.
- 6. LIST PHYSICAL CAUSES THAT WERE RULED OUT: List the physical causes that were ruled out that could cause or aggravate the mental health and/or drug/alcohol symptoms that are being exhibited or suspected.
- 7. DESCRIBE PREVIOUS MENTAL HEALTH/SUBSTANCE ABUSE SERVICES RECEIVED: Describe any known previous mental health/substance abuse services that the patient has already received.
- REFERRAL TYPE: Indicate whether this is a regular or urgent referral.

 REGULAR REFERRAL A regular referral is indicated if, in your professional **judgment**, behaviors are present that need assessing such as: alcohol/substance abuse; family conflict; troubled peer relationships; school failure; somatic symptoms, abnormal behaviors, feelings, or thoughts; growth and development deficits; or social situation problems.

 URGENT REFERRAL An urgent referral may be indicated if any of the following behaviors are present: victimization (untreated behaviors still evident); witness to death/substantial physical violence; at imminent risk of placement in restrictive setting; delusional, out of touch with reality; self-destructive behavior; destroying property; torturing animals; fire setting; sexually acting out; and suicidal behavior/ideation. Please contact the mental health provider, alcohol/substance abuse provider, or crisis response services immediately as appropriate.
- REFERRED TO: Indicate where referred mental health assessor, substance abuse assessor, and/or Regional Support Network.
- 10. REASON FOR REFERRAL: Describe the reason this patient is being referred for a mental health or alcohol/substance abuse assessment.
- 11. PHYSICIAN'S/PHYSICAL EXAMINER'S SIGNATURE: The signature of the medical provider performing the Healthy Kids/EPSDT medical screen. This may be a physician, Advance Registered Nurse Practitioner, or Physician's Assistant.

SECTION III. PATIENT INTERPRETATION CERTIFICATION

The language interpreter that explained this form and its' purpose to the patient or parent/guardian should fill in the patient or parent/guardian's name and in what language. This should be certified by the signature of the interpreter, and should be dated (month/day/year).

SECTION IV. COMPLETED BY THE ASSESSOR AND RETURNED TO THE HEALTHY KIDS PRIMARY CARE PROVIDER LISTED ABOVE

- ASSESSMENT RECEIVED: Indicate if a mental health or substance abuse assessment or no assessment was received by the patient. If no assessment was received, explain why.
- INITIAL TREATMENT PLAN: Summarize the initial treatment plan of mental health and/or alcohol/substance abuse services you recommend the patient should receive.
- 3. EXPLAIN WHY IF NO SERVICES FOR THE PATIENT ARE NEEDED: If no mental health and/or alcohol/substance abuse services are recommended, explain why.
- 4. ASSESSOR'S NAME, DATE: Sign the mental health or alcohol/substance assessor's name and date of the assessment.
- 5. TELEPHONE NUMBER: The telephone number of the mental health or alcohol/substance abuse assessor.